TABLE OF CONTENTS

STATE OF KANSAS

NON STATE EMPLOYEE HEALTH PLAN GUIDEBOOK

INTRODUCTION

STATE OF KANSAS

NON STATE EMPLOYEE HEALTH PLAN GUIDEBOOK

This guide provides information regarding State of Kansas Non State employee health plan.

This guide should be read carefully and retained for reference. If there are additional questions, the employee should contact their Human Resources Office or insurance point of contact person.

NOTE: This guide contains information that is current as of February 1, 2004; however, benefit information is subject to change without notice. If this document is in paper form, for the most current and complete benefit information, refer to the website address listed below:

http://da.state.ks.us/hcc/non-state.htm Go to this website and click on: Employee Benefits Guide)

OR

Go straight to: http://da.state.ks.us/hcc/documents/usd02.pdf. This address takes you directly to the Benefits Guide.

Note: *The information in this guide is intended to summarize the benefits offered in language that is clear and easy to understand. Every effort has been made to ensure that this information is accurate. It is not intended to replace the legal plan document or contract which contains the complete provisions of a program. In case of any discrepancy between this guide and the legal plan document or contract, the legal plan document or contract will govern in all cases. An employee may review the legal plan document or contract upon request. The State of Kansas reserves the right to suspend, revoke or modify the benefit programs offered. Information contained in this guide, in the State of Kansas Non State Groups Administrative Manual and in the insurance provider's certificate/contract takes precedence over verbal information.*

Nothing in this guide shall be construed as a contract of employment between the State of Kansas, Non State Participating Group and any employee, nor as guarantee of any employee to be continued in the employment of the qualified Non State Participating Group, nor as a limitation on the right of the qualified Non State Participating Group to discharge any of its employees with or without cause.

ENROLLMENT/ELIGIBILITY INFORMATION

Eligibility

Eligibility to participate in the State of Kansas Health Plan is governed by the provisions of K.A.R. 108-1-3 for educational groups and K.A.R. 108-1-4 for local units as defined by the Kansas State Employees Health Care Commission (see Appendix A-1 and A-2):

A. All employees working 630 hours or more for an educational group;

B. All employees working 1000 hours or more for a local unit as defined by the Kansas State Employees Health Care Commission.

C. An individual who is employed concurrently by two or more qualified local units in positions that involve similar or related tasks and whose combined employment by the qualified local units is not seasonal or temporary and requires at least 1,000 hours of work per year.

The employee should contact their Human Resources Office or insurance point of contact to inquire about the benefits eligibility of their position.

ENROLLMENT/ELIGIBILITY INFORMATION

Initial Enrollment Period/60-Day Waiting Period

The initial enrollment period for the Health Plan is limited. Employees should submit a completed Enrollment Form to their Human Resources Office or insurance point of contact within 31 days of their date of hire or date of new eligibility. If the forms are not submitted within 31 days of the event, the employee is not allowed to enroll until the next Open Enrollment period unless they experience a qualifying mid-year change event (see Health Plan Mid-Year Enrollment Changes in this guide).

Employees must also submit the proper supporting documentation for each dependent enrolled in the State of Kansas Health Plan. This documentation includes, but is not limited to marriage licenses and birth certificates.

If an Enrollment Form is submitted within the initial 31-day enrollment period, the effective date of coverage is the first day of the month following the completion of a 60-day waiting period. Both the 31-day and 60-day time frames begin from the first day of work in a benefits eligible position. Time spent in a benefits ineligible position will be applied to the 60-day waiting period if there is not a break in service of more than three days.

Pre-Existing Conditions

The State of Kansas Health Plan does not apply a waiting period for pre-existing conditions for new employees and their dependents. Certificates of creditable coverage from other health plans are not required.

Coverage Options

The State of Kansas Health Plan offers the following types of coverage. Please refer to the current Benefit Information and Options for Non State Employees for additional information. This document is available at the benefits website: http://da.state.ks.us/hcc/non-state.htm.

Medical and Prescription Drug – Eligibility for all medical plans is determined by the participant's county of residence (based on the city and state of residence). Employees may choose from several medical plans. Prescription drug coverage is provided for all employees/participants enrolled in any State of Kansas medical plan. All dependents enrolled in medical coverage will also be enrolled in the prescription drug plan.

ENROLLMENT/ELIGIBILITY INFORMATION

Dental – Dental coverage is available for all employees/participants enrolled in medical coverage. An employee may choose to enroll all of their dependents that are enrolled in medical coverage, or none, for coverage in the dental plan. If however, an employee elects to cover child dependents under medical AND dental coverage, the same child dependents must be enrolled in both plans.

Vision – Voluntary vision plans that offer specific coverage on lenses, frames, and on contact lenses. Employees may enroll in the vision coverage level of their choice regardless of their medical or dental insurance enrollment. However, if an employee elects to cover child dependents under medical **AND** vision coverage, the same child dependents must be enrolled in both plans.

Vision insurance is not available to new Non State Participating Groups joining the State Health Plan after the start of the Plan Year (January 1). These new groups will have the option to purchase vision insurance during the Open Enrollment Period for the next Plan Year.

Hearing Improvement Program (K-SHIP) - Employees who are enrolled in the State of Kansas Health Plan and their covered family members are eligible to receive a ten-percent discount off the cost of eligible services. Participants do not have to apply for coverage or fill out any forms to be eligible for the discount. Simply call one of the Clinics and tell them the participant is a State of Kansas Health Plan participant and schedule an appointment. At the time of the appointment, show a prescription drug plan card to verify eligibility. Hearing evaluations may be eligible for coverage under a health plan. To maximize benefit options, be sure to contact the plan and ask about coverage. If enrolled in HMO coverage, obtain a referral from the member's primary care physician before obtaining services.

Identification Cards - Separate identification (ID) cards and/or certificates of coverage for medical, prescription drug, dental and vision coverage will be sent to participants after the State of Kansas and the health plan(s) have processed the new enrollment elections.

The health plans will mail ID cards and/or certificates of coverage directly to the participant's home address. If an employee does not receive ID cards and/or certificates of coverage, the employee should contact the applicable health plan and request ID cards and/or certificates of coverage sent to them.

OPEN ENROLLMENT INFORMATION

Annual Open Enrollment Period

Open Enrollment for the Health Plan is usually held during October each year. A participant who enrolls during the Open Enrollment period will have coverage effective January 1 of the new Plan Year.

Pre-Existing Conditions

The State of Kansas Health Plan does not apply a waiting period for pre-existing conditions for employees and their dependents. Certificates of creditable coverage from other health plans are not required.

Newly Eligible Employees

A newly eligible employee may enroll during their initial enrollment period. Enrollment forms should be submitted within 31 days of date of hire. If they complete initial enrollment before the 31-day deadline expires, the coverage will become effective the first day of the month following their 60-day waiting period. In addition, the employee may complete Open Enrollment for different coverage to be effective the beginning of the upcoming Plan Year.

Identification Cards

New identification (ID) cards and/or certificates of coverage for Open Enrollment changes will be mailed to the participant's home address in mid-December prior to the start of the new Plan Year. New ID cards and/or certificates of coverage will generally be mailed only if the employee has changed either a health plan or coverage level(s).

Beginning in January of the new Plan Year, if a participant has not received a new ID card and/or certificate of coverage as listed above, the employee should contact the health plan and request ID cards and/or certificates of coverage.

HEALTH PLAN

COST OF COVERAGE

Participating Non State Participating Groups employee and employer contributions for the State of Kansas Health Plan are subject to change. Employee rates may be adjusted at the beginning of each plan year.

Health Plan rates are based on the following criteria:

A. The amount paid by the Participating Group:
   1. For full-time employees, the Participating Group is required to contribute not less than approximately 95% of the cost of single coverage and not less than approximately 45% of the cost for dependent coverage. Participating Groups may choose to pay more than the required amount for employee and dependent coverage.
   2. For part-time employees, the Participating Group contributes approximately 75% of the amount contributed for full-time employees.

B. Annual salary range of the employee's position
   Salary Range 1: annual salary less than $27,000
   Salary Range 2: annual salary from $27,000 to $47,000
   Salary Range 3: annual salary of $47,000 or more

C. Health (medical/prescription drug, dental and vision) plans selected.

D. Coverage level selected.

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NOTE: For current Health Plan rates, employees should contact their Human Resource Office or insurance point of contact person.

DEFINITION OF DEPENDENT

A dependent is eligible to be covered under the State of Kansas Health Plan if they are one of the following:

A. An employee's lawful wife or husband. When the employee is divorced from the lawful wife or husband, the ex-spouse is no longer eligible to participate in the State of Kansas Health Plan except as allowed under COBRA continuation coverage. A three page affidavit (see your Human Resources Office) must be completed and submitted for common law spouse consideration.

B. An employee's unmarried child or stepchild who:
   1. Is less than 23 years of age;
   2. Does not file a joint tax return with another taxpayer;
   3. Receives more than half of their support from the employee (children of parents who are either divorced, legally separated or live apart for the last six months of the calendar year and who live with either or both parents for more than six months of the year may meet this support test if both parents cumulatively provide more than one-half of the child's support);
   4. Is a U.S. citizen, a U.S. national or a resident of the U.S., Canada or Mexico at some time during the tax year; and
   5. Either resides with the employee for more than six months of the year or does not reside with the child's brother, sister, grandparent, aunt or uncle for more than six months of the year.

C. The word "child" means in addition to the employee's own or lawfully adopted child, any stepchild or a child for whom the employee has legal custody. If the employee is divorced from the natural parent of the stepchild, such child no longer qualifies as the employee's stepchild, and is no longer eligible for coverage. As used in the preceding sentence, the term natural parent includes an adoptive parent.

D. The child of an employee's covered dependent child if such grandchild resides in the employee's household and meets the criteria of section (B) (1) through (5) listed above. A one-page affidavit (see your Human Resources Office) must be completed and submitted along with a copy of the grandchild's birth certificate.

E. An employee's unmarried child who is over the age of 23, who is not capable of self support because of mental retardation or severe physical handicap which existed prior to attaining age 23, and who has maintained continuous group coverage as a dependent child prior to attaining age 23. Such child must be chiefly dependent on the employee for support. A two-page affidavit (see your Human Resources Office) must be completed and submitted.

ADDITIONAL DEPENDENT INFORMATION

Children of divorced parents – An employee may cover their dependent children if the children receive at least 50% of their support from one or both parents.

Grandchild - An employee may cover a grandchild if the employee has legal custody or has adopted the child; or if the grandchild lives in the employee's home, is the child of a covered dependent child, and the employee provides more than one half of the grandchild's support.

Ex-Spouse – When the employee is divorced from their lawful wife or husband, the ex-spouse is no longer eligible to participate in the State of Kansas Health Plan except as allowed under COBRA continuation coverage.

Dependents who are Employees – An employee who is eligible for coverage in the State of Kansas Health Plan is not eligible to be covered as a dependent in the State of Kansas Health Plan.

Dependents May Not Be Covered in Duplicate – Eligible dependent children may not be covered by more than one participant in the State of Kansas Health Plan.

Dependents residing out-of-country

A spouse who is not a U.S. citizen or who resides in another country is eligible for PPO coverage when the employee is newly eligible, when newly married or at Open Enrollment. The employee will not be allowed to add the spouse to coverage if the spouse moves to the United States during the Plan Year.

Dependent children who are not U.S. citizens and who reside in another country are not eligible for coverage until they move to the United States. The employee will be allowed to add the children to coverage if the children move to the United States during the Plan Year (if added within 31 days of the move). However, if added to PPO coverage and the dependent children later return to another country during the Plan Year, coverage may not be dropped for these children until the next Open Enrollment period (unless enrolled on an after-tax basis).

Adopted child - An employee may cover an adopted child if the petition for adoption has been filed with the court, if the employee has a placement agreement for adoption, or if the employee has been granted legal custody of the child. Supporting documentation must be provided in English and must be submitted to Benefits Administration. Adopted children who are not U.S. citizens and who reside in another country are not eligible for coverage until they reside in the United States.

ADDITIONAL DEPENDENT INFORMATION

The State of Kansas and the health plans reserve the right to request documentation to support proof of dependency and/or residency.

NOTE: When enrolling dependent(s) for coverage in the State of Kansas Health Plan, the employee must certify that the dependent(s) meet the requirements for dependent coverage for the year in which the dependent(s) are being enrolled. Any attempt to enroll dependent(s) that do not meet the requirements will be considered fraud and will be subject to penalties as prescribed by law.

ENROLLMENT ELECTIONS

Enrollment elections must be made on a State of Kansas Enrollment Form. Enrollment Forms are available from your Human Resources Office or point of contact person and must be returned to them for processing.

General Information

Tax Status - If the Non State employer offers a cafeteria benefit program the employee must elect how to pay for the cost of coverage - before tax or after tax. Payment status may only be changed during open enrollment.

Medical Insurance Plan - Eligibility for all medical plans is determined by county of residence (based on the city and state of residence according to the U.S. Census Bureau). For HMO's, the employee and all covered dependents must reside within the designated enrollment area for the particular HMO. Employees may choose from any currently offered medical plan for which they are eligible.

Medical and Prescription Drug Coverage Level - All employees and dependents enrolled in medical coverage will have the same level of prescription drug coverage. Employees may choose from among the following coverage levels for medical and prescription drug:

1 Member Only
2 Member and Spouse Only
3 Member and Child(ren) Only
4 Member and Family - with Spouse and Child(ren)
5 Waive Medical/Dental/Prescription Drug Coverage

HEALTH PLAN

Dental Coverage Level - Single dental coverage is provided for all employees enrolled in medical coverage. An employee may enroll in dental coverage only if they enroll in medical/prescription drug coverage. Employees may choose from among the following dental coverage levels:

1 Member Only
D Member and Dependent(s) - dependent dental is available only if the same dependent medical/prescription drug coverage level is selected. All child dependents elected for coverage in the Dental plan must match those child dependents enrolled in medical/prescription drug coverage.

Vision Coverage Level - Employees may elect any level of vision coverage regardless of enrollment in a medical or dental insurance plan. However, if child dependents are covered under the medical plan, the child dependents covered under the vision plan must match those in the medical plan. Employees may choose from among the following coverage levels:

1 Member Only
2 Member and Spouse Only
3 Member and Child (ren) Only
4 Member and Family
5 Waive Vision Coverage

Identification Cards - Identification cards and/or certificates of coverage will be mailed to the employee's home. If an employee does not receive an ID card for each plan, they should contact the health plan and request an ID and/or certificates of coverage.

Required Information - For each employee and covered dependent, the following information is required:

- Relationship (e.g., child, spouse, stepchild, etc.). Documentation proving dependency or relationship must be provided.
- Full Name
- Social Security Number (for everyone over 60 days old)
- Gender
- Date of Birth
- PCP (Primary Care Physician) Number - for initial enrollment only in HMO plans. Employees should telephone their HMO to verify that their selected physician is a participating primary care physician. For all other PCP changes, the employee must call their medical plan.

NOTE: To be enrolled as a dependent under the employee's coverage in the Non State Health Plan, the employee and their dependent must be enrolled in the same health insurance plan.

MID-YEAR ENROLLMENT CHANGES

Changing Primary Care Physician (PCP) on HMO Plans

In order for an employee to change their PCP designation during the middle of a Plan Year, **the employee must telephone their elected medical plan**. This is the **only** method an employee can use to change a PCP designation. PCP changes are the sole responsibility of the employee/participant. Do not contact your Agency's Human Resources office or the State of Kansas Benefits Administration. Failure on the part of the employee/participant to do this may result in no payment of benefits.

The change in PCP will generally become effective the first day of the month following the change. Medical plan telephone numbers are listed on the employee's ID card or can be found in the Health Plan Summary Booklet.

It is the employee's responsibility to verify that the PCP selected is appropriate for the enrolled medical plan and that the PCP is accepting new patients or is limited to existing patients only. In the event that an employee or dependent that is enrolled in coverage has selected an ineligible PCP, benefits will not be paid.

Moving from one Enrollment Area to Another

Employees who move from one enrollment area to another during the Plan Year have the following enrollment options:

A. If the employee is enrolled on a pretax basis, a new medical plan may be selected only if the old medical plan is not available in the new area of residence.
B. If enrolled after-tax, and a medical plan is now available that was not available in the old area of residence, the employee may change without restriction to the same level or lower level of coverage (e.g., family to single) with the new medical plan, including HMO's. The new medical plan may be selected even if the prior medical plan is still available in the new area of residence.

C. Employees with PPO coverage who move from a non-HMO county to a HMO county may change to any available HMO.

If a change to the new medical carrier is desired, a Change Form must be completed and signed within 31 days of the move. The effective date of change in coverage will be the first day of the month following the move. If the move occurs on the first day of a month, the change effective date will be that day. The Benefits Section must receive forms within 10 days of the completion of the form.

If the form is not completed within 31 days of the move, the change will be effective the first day of the month following completion of the form.

MID-YEAR ENROLLMENT CHANGES

NOTE: Eligibility is based on the state and city of the participant's current home mailing address. The county is then determined by the participant's city and state according to the U.S. Census Bureau - regardless of the location of the actual residence or personal property of the participant.

Active Military Duty

Employee coverage ends effective the last day of the month in which the employee goes on military leave.

Employees on military leave without pay may continue coverage for the next 30 days; the agency will continue to make the Health Plan employer contribution for those 30 days. The employee is required to remit his/her premium (regular payroll deduction amount) to the agency to retain coverage during the 30 days following the effective date of the military leave without pay.

Employees may continue coverage in the Health Plan beyond the 30 days leave without pay timeframe, but must remit the full premium. There will be no agency contribution. An employee with spouse, children, or full family coverage may elect to drop themselves and keep their spouse and/or children covered in the State Health Plan. However, employees must make the change within 30 days of the effective date of the military leave without pay.

If group health insurance is continued, it will be the primary payer of claims and their military coverage will be secondary.

A. Employees and/or their dependents who elect to discontinue State of Kansas Health Plan coverage and who have primary coverage provided by the military will be allowed to rejoin the provider coverage they left when they return to active employee status.
B. Employees on military leave during Open Enrollment may enroll in any coverage for which they are eligible, without penalty, upon their return to active employee status.

MID-YEAR ENROLLMENT CHANGES

Retirement

When an employee retires from a Non State Participating Group, the employee must indicate on a Change Form whether or not they wish to continue in the State of Kansas Health Plan through the Direct Bill Program. If continued coverage is desired, a Change Form must be completed 30 days prior to the employee's retirement in order to ensure continuous coverage between active employee coverage and Direct Bill coverage.

The effective date of the change to the Direct Bill Program will be the first day of the month following the employee's last day at work. The coverage ending date for active coverage will be the last day of the last month that the employee is active. Those enrolled in the Direct Bill Program must pay their premiums by automatic bank draft. Deductions will be made from the individual's bank account on approximately the 10th of each month for coverage for that month.

The employee may change their medical plan at the time of retirement and subsequent enrollment in the Direct Bill Program. Dependents may be dropped from coverage upon retirement; however, dependents may be added to coverage only if there is a qualifying mid-year event. Dependents may also be added to coverage during the next Open Enrollment period.

If the employee and/or covered spouse are age 65 or older when the employee retires, the employee and/or spouse must be enrolled in Medicare Part A. If the individual does not currently have Medicare Part B, they must apply for Medicare Part B. The Social Security Administration requires that the Agency Human Resources Office send retiring employees a letter containing health insurance information necessary to process the application for Medicare Part B coverage. When applying for Medicare Part B, the employee should present the letter to the local Social Security office.

Kansas Senior Plan C is available to Medicare eligible retirees and their Medicare eligible dependents. Kansas Senior Plan C offers the same medical benefits as the Medicare Supplemental Plan C. Both are designed to coordinate with traditional Medicare coverage. See the current Health Plan Summary booklet for more information.

For more information on retirement, the employee should contact their Human Resources Office or insurance point of contact person.

MID-YEAR ENROLLMENT CHANGES

Additions to Coverage

Newly Eligible Dependents
Dependents shall become newly eligible on the latter of:

1. The employee's initial date of eligibility; or
2. The date the individual first becomes an eligible dependent of the employee. This includes the following:

    A. A new spouse and/or stepchildren due to marriage;
    B. A new dependent child due to birth or adoption (the petition for adoption must have been filed with the court or there must be a placement agreement);
    C. A new dependent child due to new legal custody or guardianship (not power of attorney); or
    D. Dependent children listed on a Medical Withholding Order (K.S.A. 23-4,105).

Coverage for newly eligible dependents (see #2 above) may be added mid-year to the employee's current medical plan, but only if all of the following requirements are met:

1. The dependent is added to coverage within 31 calendar days of the qualifying mid-year event creating the new eligibility (by completing a Change Form);

2. Written documentation is provided (such as a copy of the birth certificate, petition for adoption, placement agreement, marriage license, custody agreement, etc.); and

3. The change in coverage is consistent with the qualifying event and/or complies with HIPAA regulations.

Coverage for newborn/adopted children will generally be effective on the date of birth, the date of filing of the petition for adoption or the date of the placement agreement. The employee will be responsible for contributions the first of the following month. However, no benefits will be provided for the newborn/adopted child until the Change Form has been processed.

If the petition for adoption or the placement agreement is within 31 days of the birth of the child, the effective date of coverage will be the date of birth and the employee will be responsible for contributions the first of the following month.

MID-YEAR ENROLLMENT CHANGES

Non-Newly Eligible Employees and Dependents

Non-newly eligible employees and dependents are defined as:

> Employees and/or dependents for whom 31 days have passed since their initial eligibility for coverage.

Non-newly eligible employees and/or dependents may be added or dropped from Health Plan coverage (not including vision coverage) during the Plan Year but only if all of the following mid-year change requirements are met:

1. The change is a result of one of the events listed on the following pages and/or complies with HIPAA regulations,

2. The change is requested within 31 calendar days of the event (by completing an Enrollment or Change Form),

3. Written documentation of the event is provided (such as a divorce decree, death certificate, custody agreement, or statement from a spouse's employer), and

4. The change in coverage is consistent with the event and/or complies with HIPAA regulations.

NOTE: For mid-year enrollment changes, the effective date of coverage or change in coverage will generally be the first day of the month following the event (assuming all form requirements have been met). For events that occur on the first day of a month, the coverage effective date will be that day. However, if a death occurs on the first day of a month, the change effective date will be the first day of the following month.

Deletions from Coverage

Dependent dental coverage may not be dropped during the Plan Year, unless dependent medical and prescription drug coverage are also dropped.

Vision coverage may not be dropped during the Plan Year. In addition, vision coverage cannot be changed during the Plan Year unless due to either a newly eligible dependent or a dependent becoming ineligible.

MID-YEAR ENROLLMENT CHANGES

PRETAX EVENTS

If an employee is enrolled pretax, and any addition or deletion to coverage will result in a change in employee contribution, there must be a qualifying status event for the change to be approved. Enrollment changes must also be consistent with the event and/or must comply with HIPAA regulations. Employees may change pretax status only during Open Enrollment each year (unless the 60-day waiting period was waived for initial enrollment). The change in status event must result in a gain or loss of eligibility for coverage in an employer-sponsored group health insurance plan. This gain/loss/change can be for the employee, spouse, or dependent and can be under either the State's plan or a plan sponsored by the spouse or dependent's employer. The requested change of election must then correspond with the gain/loss of coverage, and must be confirmed with documentation in the form of a letter from the employer on the employer's letterhead. All changes must be requested within 31 days of the event.

Employees who are enrolled in group health insurance on a pretax basis may make mid-year additions and deletions from coverage based on the following events.

A. Employee's marriage - may add or drop entire family if the family is picked up under the new spouse's employer's plan because the entire family is now newly eligible. The entire family is not newly eligible if the spouse's employer covered unmarried domestic partners.
B. Final divorce (the first and last pages of the final divorce decree must be attached to the Enrollment or Change Form).
C. Birth or adoption of a dependent - may add entire family. May drop entire family only if the status change is due to a birth or adoption, and those family members are now newly eligible under some other employer's plan.
D. Gain or loss of legal custody of a dependent.
E. Change from part-time to full-time or from full-time to part-time employment by employee or spouse that affects cost, benefit level, or benefit coverage for employee, spouse and/or dependents. Change from benefits eligible position to benefits ineligible position by the employee, spouse or dependent. Termination or commencement of employment (includes retirement) of employee, spouse or dependent which affects benefits coverage for employee, spouse and/or dependents (an employee may change medical plan at the time of retirement). Any employment status change that affects eligibility.
F. Unpaid leave of absence by employee, spouse or dependent which affects the benefits coverage of employee, spouse and/or dependents. If the employee is rehired or reactivated within 30 days, he/she must step back into the same enrollment unless he/she experiences a status change event.

PRETAX EVENTS (cont.)

G. Significant changes in the health insurance coverage of the employee or spouse attributable to the spouse's employment. The loss of one participant's PCP is not an allowable change. The change under a spouse's plan must be the result of a status change event and result in a gain/loss of eligibility and coverage. An employee can make a mid-year change due to an Open Enrollment change made by a spouse or dependent.
H. Employee, spouse or dependent being called to active military duty.
I. Expiration of COBRA continuation benefits from a previous employer for an employee, spouse or dependent.
J. Change of residence of employee that requires a change of medical plans.
K. Death of a spouse or dependent.
L. Dependent turning age 23 or marrying (coverage will end the last day of the month of the birthday or date of marriage). If the birth date or date of marriage is on the first day of a month, the coverage ending date for that dependent will be the last day of the preceding month.
M. Employee, spouse or dependent gaining or losing government-sponsored medical card coverage, although terminating coverage is not allowable if the employee becomes covered under programs like SHIPS because these programs are not supposed to replace existing insurance. This may apply to other government card coverage.
N. Employee, spouse or dependent losing Medicare eligibility or becoming eligible for Medicare, and electing Medicare coverage as primary.
O. Dependent children identified under a Medical Withholding Order (K.S.A. 23-4,105) or Qualified Medical Child Support Order (the State group has the authority to add these dependent children without the consent of the employee).
P. Court Order requiring addition or deletion of coverage for a dependent child.
Q. Spouse or dependent moving outside an HMO enrollment area (employee may drop dependent coverage or may change medical plans in order to continue dependent coverage).
R. Failing to meet the 50% support requirement for a dependent child during the Plan Year. A notarized written statement from the employee must be attached to the Change Form, which states that the dependent does not receive 50% of their support from the employee for the entire tax year. The date of event will be the date of completion of the Change Form and the effective date will be the first day of the following month. If the Change Form is completed on the first day of a month, the effective date will be that day. If approved and coverage is dropped for the dependent, the dependent cannot be added back to coverage during the Plan Year.
S. Dependent children losing eligibility/coverage under another group health insurance plan.

IV. AFTER-TAX EVENTS

Employees who are enrolled in Group Health Insurance on an after-tax basis may make mid-year additions and deletions from coverage due to the following events and subject to the requirements listed in Section II:

A. All events as listed under Pretax Events;
B. Removing employee and/or dependents from group health insurance coverage for any reason (no documentation is required).

HIPAA DISCLOSURE REQUIREMENTS

Under the Department of Labor's (DOL) rules governing plan disclosure requirements, health plan sponsors must provide participants and beneficiaries with certain information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) amended the content requirements for employee communication materials for group health plans. The required disclosure information is as follows:

Plan Participants' Rights

If a participant has any questions about this guide, their health benefits or about their rights, the participant should contact the following office:

U.S. Department of Labor
Pension and Welfare Benefits Administration
City Center Square, 1100 Main Street
Kansas City, Missouri 64105

Telephone: 816-426-5131

The participant may also contact the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210.

Newborns and Mothers Health Protection Act

Group health plans and health insurance providers offering group health insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery. Nor may they restrict benefits for any hospital length of less than 96 hours following a cesarean section, or require that a medical plan obtain authorization from the plan or insurance provider for prescribing a length of stay not in excess of the above periods.

Prior Coverage Certification

Written certification of health plan coverage is automatically provided either when an individual's coverage is lost under the State of Kansas Health Plan, when coverage is lost under COBRA continuation or upon request within 24 months after either loss of coverage. Certification will be sent to the individual at their last known address and will identify the covered person, the period of coverage and any waiting periods.

HIPAA DISCLOSURE REQUIREMENTS

Special Enrollments/Notice of Employee Rights

If an employee is declining enrollment for himself/herself or their dependents (including their spouse) because of other health insurance coverage, the employee may in the future be able to enroll himself/herself or their dependents in this plan. This is allowable provided that the employee requests enrollment (by submitting a completed Enrollment Form) within 31 days after the other coverage ends. In addition, if the employee has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may be able to enroll himself/herself and their dependents, provided that the employee requests enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

NOTE: The State of Kansas requires that written documentation of the marriage, birth, adoption or placement for adoption be provided. Employees should refer to the Mid-Year Enrollment Changes section in this guide for more information concerning special enrollments.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Effective January 1, 1999, the Federal Women's Health and Cancer Rights Act of 1998 requires group health plans, insurance companies, and health maintenance organizations (HMOs) that provide benefits for mastectomies to also provide coverage for:

A. Reconstruction of the breast on which the mastectomy was performed;

B. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

C. Prostheses and treatment of physical complications for all stages of a mastectomy, including lymphedema (swelling associated with the removal of lymph nodes).

The deductible and coinsurance provisions applicable to these benefits are consistent with the deductible and coinsurance provisions governing other benefits provided by the State of Kansas Health Plan. Coverage will be provided in a manner determined from consultation with the attending physician and the patient.

Any questions concerning the above benefits provided under the State of Kansas Health Plan should be directed to the employee's medical plan.

CONTINUATION OF COVERAGE - COBRA

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) was enacted in 1986. The law requires that most employers sponsoring Health Plan plans offer employees and their families the opportunity for a temporary extension of health coverage, at group rates, in certain instances where coverage under the plan would otherwise end.

This section is intended to inform employees of their rights and obligations under the continuation of coverage provisions of the law. **Both the employee and spouse should read this section carefully.**

If the **employee** is covered by Health Plan, the employee has the right to choose continuation coverage if they lose their coverage due to:

- A reduction in their hours of employment; or
- The termination of their employment (for reasons other than gross misconduct).

If the **spouse of an employee** is covered by the employee's Health Plan, the spouse has the right to choose continuation coverage if they lose coverage due to any of the following reasons:

- The death of their spouse (the employee);
- Termination of their spouse's employment (for reasons other than gross misconduct) or reduction in their spouse's hours of employment; or
- Divorce or legal separation from their spouse.

If a **dependent child of an employee** is covered by the employee's Health Plan, the dependent child has the right to choose continuation coverage if they lose coverage due to any of the following reasons:

- The death of their parent (the employee);
- Termination of their parent's employment (for reasons other than gross misconduct) or reduction in their parent's hours of employment;
- Their parent's divorce or legal separation;
- Their parent becoming entitled to Medicare; or
- The dependent child ceasing to be a dependent under the Health Plan (such as turning age 23 or marrying).

CONTINUATION OF COVERAGE - COBRA

Under the law, the employee has the responsibility to inform their Human Resources Office or insurance point of contact of the occurrence of certain events. These events include divorce or legal separation, or a child losing dependent status under the Health Plan. Notice must be given within 60 days of the latter of (1) the date of the event or (2) the date on which coverage would end under the plan because of the event. The Human Resources Office or insurance point of contact has the responsibility to notify the Health Benefits Section of the employee's death, termination, or reduction in hours of employment.

When the Health Benefits Section is notified that one of these events has happened, a COBRA notification letter will be mailed to the employee or the family member detailing the right to choose continuation coverage. The individual has 60 days from the date of the qualifying event OR the date of the letter, which ever is later, to elect continuation coverage by returning the Enrollment Form that is enclosed with the notification letter. People covered under COBRA will receive information and make payments to a third party administrator, currently CompLink.

The individual does not have to show that they are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to their eligibility for coverage. The State of Kansas reserves the right to terminate the individual's COBRA coverage retroactively if they are determined to be ineligible.

If the individual does not choose continuation coverage, their Health Plan coverage will end on the last day of the month in which the qualifying event occurred. If COBRA coverage is chosen, the effective date will be retroactively assigned to the coverage ending date of the active employee coverage.

If the individual chooses continuation coverage, the medical plan is required to provide coverage which, as of the time coverage is being provided, is identical to the coverage provided to similarly situated active employees or family members. The law requires that the individual be afforded the opportunity to maintain continuation coverage for 36 months unless they lost group health coverage because of a termination of employment or reduction in hours. In those cases, the required continuation coverage period is 18 months. These 18 months may be extended to 36 months from termination of employment if other events such as a death, divorce, or legal separation occur during that 18-month period.

The 18 months may be extended to 29 months if an individual has been approved as disabled (for Social Security disability purposes within 60 days of the qualifying event) and the medical plan is notified of that determination within 60 days. The affected individual must also notify the medical plan within 30 days of any final determination that the individual is no longer disabled. In no event will continuation coverage last beyond 3 years from the date of the original COBRA qualifying event.

CONTINUATION OF COVERAGE - COBRA

Under the law, the individual may have to pay all or part of the premium for their continuation coverage. Premiums are due on or before the first day of each month of coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium. The law also says that, at the end of the 18 month or 3 year continuation coverage period, the individual must be allowed to enroll in an individual conversion health plan provided by the medical plan(s).

However, the law also provides that the individual's continuation coverage may be terminated for any of the following four reasons:

- The State of Kansas no longer provides Health Plan coverage to any of its employees or affiliated groups;
- The premium for the continuation coverage is not paid on time;
- The individual becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition they may have; or
- The individual extended coverage for up to 29 months due to their disability and there has been a final determination that they are no longer disabled.

For additional information concerning COBRA continuation coverage, the employee or spouse should contact the employee's Human Resources Office or insurance point of contact.

CONTINUATION OF COVERAGE – DIRECT BILL PROGRAM

An individual is eligible for participation in the State of Kansas Health Plan as a Direct Bill Program participant if they are:

A. Retired Non State employees who receive retirement benefits by KPERS warrant;

B. Totally disabled former Non State employees who are receiving KPERS disability benefits;

C. Surviving spouses and/or dependents of enrollees following death of the individual who was participating in the State of Kansas Health Plan (if dependent coverage for the surviving spouse and/or dependents was in force immediately preceding the participant's death).

D. Active employees who were covered under the State of Kansas Health Plan immediately before going on approved leave without pay in accordance with the practices of the qualified Non State Group.

For more information on the Direct Bill Program, the employee should contact their Human Resources Office or insurance point of contact.

CONTINUATION OF COVERAGE – FAMILY AND MEDICAL LEAVE ACT

The Federal Family and Medical Leave Act of 1993 (FMLA) may apply to some Non State Employer Groups participating in the State Health Plan. Please contact your Human Resource office or insurance point of contact to determine eligibility under FLMA.

FLMA provides that eligible employees are entitled to continuation of Health Plan benefits up to a maximum of 12 weeks for:

- The serious health condition of the employee that makes the employee unable to perform the functions of the employee's position; or

- Care for the employee's spouse or parent with a serious health condition; or

- The birth of the employee's child or placement of a child with the employee for adoption or foster care and care of the child upon birth or placement in the employee's home.

  For FMLA applicable groups, the employer continues to pay its respective portion of the group health insurance premium.

For more information concerning this continuation program, the employee should contact their Human Resources Office or insurance point of contact.

HealthQuest Mission

To partner with employees to improve their health and well-being and to reduce health care costs.

HealthQuest, the State of Kansas health promotion program, is designed to enhance the health and wellness of employees and assist in the containment of health care costs. The Kansas State Employees Health Care Commission and Kansas Health Policy Authority jointly administer this program. Current programs and services are for State of Kansas employees and Non-State Public Employer groups.

Visit the HealthQuest web page for additional information about health and safety programs available to employees: http://da.state.ks.us/ps/subject/healthquest.htm

Disease Management Programs

HealthQuest is partnering with Caremark, the State's Pharmacy Benefit Manager, to provide disease management programs. These programs focus on identified areas of the Health Plan and integrate pharmacy benefits, clinical services and patient support services into programs designed to help people achieve optimal health.

Caremark administers a series of disease management programs. The goal of these programs is to assist people in maintaining or enhancing their health through self-care management and effective communication with their physician. Many of the patient interventions used in the Building Better Health series include the use of condition or disease specific educational booklets, seasonal health reminder messages, medication cards, resource lists, telephonic outreach and other educational messaging. Some important facts to remember are:

- The programs are totally voluntary.
- The programs are completely confidential. No participant's personal medical information is shared with any State of Kansas agency.
- The programs are free to eligible members.
- The programs are a great way to become a more knowledgeable consumer of health services.

Caremark gears their interventions towards physicians and patients in an effort to reinforce standards of physician practice, improve preventive care, increase communication between the patient and healthcare team and foster patient self-management skills. The following are descriptions of the disease management programs.

Cardiovascular Risk Reduction

According to the Centers for Disease Control, over 60 million Americans have some form of cardiovascular disease (CVD). Moreover, CVD is the nation's number one killer for men and women among all racial and ethnic groups. In 2000, CVD cost the nation $215 billion in direct and indirect health care expenditures. Despite understanding the role of cholesterol management, only one fourth of patients recommended for cholesterol therapy are being treated, more than half discontinue use by the end of year one and many are not treated to target levels.

Depression Management

Depression is a serious and common illness that can be effectively treated. According to the National Institute of Mental Health, almost 19 million Americans suffer from a depression disorder each year. Depression can affect anyone, although the risk is often greatest in people with chronic conditions.

To sum it up, these Disease Management programs are intended to help participants with chronic disease manage their care and improve their quality of life. More information about these and other health concerns are available to plan participants through the Building Better Health website. The identified programs will offer participants with chronic conditions an opportunity to take the next step in managing their care.

Educational Services

- The bi-monthly *HealthQuest eNewsletter* provides a wealth of health information covering nutrition, exercise, stress management, and self-care and much more. Current and past issues of the newsletter are online at: http://da.state.ks.us/ps/subject/healthquest/newsletters.htm
- Agencies can request health promotion presentations on a variety of topics including stress management, self-care, exercise, healthy eating, and healthy aging.

HealthQuest Wellness (Winterfit, Springfit, Summerfit, Fallfit) is an online wellness program to help employees stay healthy and active year round. Employees can sign up to receive tips and strategies to support year-round wellness. Currently 4,200 employees subscribe. For more information and to subscribe, visit this website: http://da.state.ks.us/ps/subject/winterfit/2004/welcome.htm

LIFELINE

LIFELINE, the State of Kansas employee assistance program, provides free, confidential help to any employee or immediate family member experiencing personal problems. In-person or telephone counseling is available for many problems including the following:

- Stress
- Depression
- Marital or family problems
- Child care and elder care issues
- Financial problems
- Legal Issues
- Drug or alcohol issues.

LIFELINE benefits have been expanded to include 1-4 office visits for each mental health issue. When an employee, immediate family member, or a co-worker are troubled by life stresses and events, they can call 1-800-284-7575 for free counseling and referral services. The calls and visits are completely confidential. They can call any time, any day.

Special Services for Employees

- **Legal Advice:** The employee can receive legal consultation with an attorney. The employee will receive a 25% discount if they retain the attorney for resolution of their issue.
- **Financial Advice:** A wide variety of financial services are available when the employee calls.
- **Dependent Care Consultation and Referral:** If the employee is concerned about appropriate care for an aging parent (e.g., Alzheimer's, special health issues, nursing homes), they can talk with a Certified Geriatric Care Manager for consultation and referral services.
- **Day Care Referrals:** Call LIFELINE for consultation and referral services.
- **Extended Benefit** for employees and immediate family members for 6 months after any layoff action.
- **Monthly Messages –** e-newsletter with tips on staying mentally healthy

- **Healthy Weight Program** (5-week teleclass series)
  more info and sign up>> **http://www.lifelineeap.com**

- **Life Coaching** on a variety of topics (stress management, self-confidence and self-esteem, building sound relationships; strengthening your career)
  more info and sign up>> **http://www.lifelineeap.com**

Special Services for Agencies

Human Resource Managers can contact HealthQuest for information about the following offerings:

- **Critical Incident/Grief Counseling Sessions** - LIFELINE provides critical incident and grief counseling and resource materials for employee groups experiencing trauma or major loss.
- **Supervisory Training** - "How to Use LIFELINE as a Supervisory Tool" is a seminar designed for supervisors and is offered annually or by special request.
- **Fitness-For-Duty** program to help agencies recognize behaviors in employees that signal potentially dangerous situations, and offer the resources and ability to react in a swift but fair manner. Additional information about the Fitness for Duty agency offering: http://da.state.ks.us/ps/subject/healthquest/fitnessduty.htm

LIFELINE can be accessed 24-hours a day by calling 1-800-284-7575. For more specifics about the program, go to the HealthQuest web page:
http://da.state.ks.us/ps/subject/healthquest/lifeline.htm

APPENDIX A

K.A.R. 108-1-3

108-1-3. School district employee health care benefits plan.

(a) **Definitions.**

(1) "Commission" means the Kansas state employees health care commission.

(2) "Qualified school district" means a public school district, community college, area vocational technical school, or technical college that meets the terms, conditions, limitations, exclusions, and other provisions established by the commission for participation in the school district employee health care benefits component of the health care benefits program and has entered into a written agreement with the commission to participate in the program.

(3) "School district employee" means any individual who is employed by a qualified school district and who meets the definition of employee under K.S.A. 74-4932(4), and amendments thereto, except that the following employees shall be employed in a position that requires at least 1,000 hours of work per year:

(A) Employees of community colleges; and

(B) Employees of area vocational technical schools and technical colleges that are not governed by a unified school district.

For purposes of this definition, a technical college shall be a participating employer under K.S.A. 74-4931, and amendments thereto, in accordance with K.S.A. 72-4471, and amendments thereto.

(4) "School district plan" means the school district employee health care benefits component of the health care benefits program.

(b) **Active participants.** Subject to the provisions of subsection (c), each school district employee shall be eligible to participate as an active participant in the school district plan. Eligibility and participation shall be subject to terms, conditions, limitations, exclusions, and other provisions established by the commission, including the amount and method of payment for employee and employer contributions.

(c) **Waiting periods.**

(1) Each school district employee whose first day of work for a qualified school district is on or after the first day on which the employee's qualified school district participates in the school district plan shall become eligible for coverage

following completion of a 60-day waiting period beginning with the first day of work for the qualified school district. Each school district employee shall have 31 days after becoming eligible to elect health insurance coverage.

(2) The waiting period established in paragraph (c)(1) shall not apply if all of the following conditions are met:

(A) The person is returning to work for the qualified school district or is transferring from another qualified school district.

(B) Immediately before leaving the prior position, the person was enrolled in the school district plan or was covered by the health care insurance plan provided by the employee's qualified school district.

(C) The break in service between the prior position and the new position does not exceed the following time periods:

(i) 30 or fewer calendar days; or

(ii) 365 or fewer days, if the person was laid off in accordance with the practices of the qualified school district.

(3) The waiting period established in paragraph (c)(1) may be waived when the chief administrative officer of the qualified school district, or the chief administrative officer's designee, meets the following requirements:

(A) The chief administrative officer or the chief administrative officer's designee shall provide both of the following certifications to the commission, or its designee, in writing:

(i) A potential new school district employee is not entitled to continuation of health benefits available from prior insurance coverage.
(ii) The waiting period poses, or will pose, an obstacle to recruitment.

(B) The chief administrative officer or the chief administrative officer's designee shall submit the request for a waiver before the employee's acceptance of the position.

(4) Each school district employee who is employed by the employee's qualified school district immediately before the first day on which the employee's qualified school district participates in the school district plan shall be subject to transitional provisions established by the commission regarding waiting periods and the date on which the employee becomes eligible to participate in the school district plan.

(5) The waiting period described in this subsection may be waived by the commission if the commission determines that failure to grant a waiver would create a manifest injustice or undue hardship on the school district employee.

(d) **Categories of direct bill participants.** Subject to the provisions of subsection (e), the classes of persons eligible to participate as members of the school district plan on a direct bill basis shall be those classes of persons listed below:

(1) Any retired school district employee who is receiving state warrants for retirement benefits;

(2) any totally disabled former school district employee who is receiving benefits under K.S.A. 74-4927, and amendments thereto;

(3) any surviving spouse or dependent of a qualifying participant in the school district plan;

(4) any person who is a school district employee and who is on approved leave without pay in accordance with the practices of the qualified school district; and

(5) any individual who was covered by the health care plan offered by the qualified school district on the day immediately before the first day on which the qualified school district participates in the school district plan, except that no individual who is an employee of the qualified school district and who does not meet the definition of school district employee in subsection (a) shall be qualified as a direct bill participant under this paragraph.

(e) **Conditions for direct bill participants.** Each person who is within a class listed in subsection (d) shall be eligible to participate on a direct bill basis only if the person meets both of the following requirements:

(1) The person was covered by the school district plan or the health care insurance plan offered by the qualified school district on one of the following bases:

(A) Immediately before the date the person ceased to be eligible for coverage, or for any person identified in paragraph (d)(5), immediately before the first day on which the qualified school district participates in the school district plan, the person either was covered as an active participant under subsection (b) or was covered by the health care insurance plan offered by the employee's qualified school district.

(B) The person is a surviving spouse or dependent of a person who was enrolled as a plan participant under subsection (b) or (d) at the time the plan participant died, and the person was enrolled in spouse or dependent coverage under subsection (g) at the time the plan participant died.

(C) The person is a surviving spouse or dependent of a person who was enrolled as a plan participant under the health care insurance plan offered by the participant's qualified school district at the time the participant died, and the person was covered under the same plan at the time the participant died.

(2) The person files a statement of election with the commission's health benefits administrator to continue coverage under the plan. The election to continue coverage shall be submitted on a form prescribed by the commission's health benefits administrator. The form shall be submitted no more than 30 days after the person ceased to be eligible for coverage, or in the case of any individual identified in paragraph (d)(5), no more than 30 days after the first day on which the qualified school district participates in the school district plan.

(f) **Continuation of benefits (COBRA) coverage.** Any individual with rights to extend coverage under provisions of public law 99-272, as amended, may participate in the school district plan, subject to the provisions of that federal law.

(g) **Coverage of spouses and dependents.** Any person who is enrolled in the school district plan under subsection (b), (d), or (f) may enroll a spouse and eligible dependent children, subject to the same conditions and limitations that apply to the person enrolled in accordance with this regulation. (Authorized by K.S.A. 75-6501 and 75-6510; implementing K.S.A. 75-6501 and 75-6508; effective, T-108-9-13-99, Sept. 13, 1999.

APPENDIX B

K.A.R. 108-1-4

Article 1: Eligibility Requirements

108-1-4.Local unit of government employee health care benefits plan.

(a) **Definitions.**

(1) "Commission" means the Kansas state employees health care commission.

(2) "Local unit" means any county, township, city, community mental health center, groundwater management district, rural water-supply district, public wholesale water supply district, county extension council, or extension district.

(3) "Local unit employee" means any individual who meets one or more of the following criteria:

(A) The individual is an appointed or elective officer or employee of a qualified local unit whose employment is not seasonal or temporary and whose employment requires at least 1,000 hours of work per year.

(B) The individual is an appointed or elective officer or employee who is employed concurrently by two or more qualified local units in positions that involve similar or related tasks and whose combined employment by the qualified local units is not seasonal or temporary and requires at least 1,000 hours of work per year.

(C) The individual is a member of a board of county commissioners of a county that is a qualified local unit, and the compensation paid for service on the board equals or exceeds $5,000 per year.

(D) The individual is a councilmember or commissioner of a city that is a qualified local unit, and the compensation paid for service as a councilmember or commissioner equals or <u>exceeds $5,000 per year.</u>

(4) "Local unit plan" means the local unit employee health care benefits component of the health care benefits program.

(4) "Qualified local unit" means a local unit that meets the terms, conditions, limitations, exclusions, and other provisions established by the commission for participation in the local unit employee health care benefits component of the health care benefits program and that has entered into a written agreement with the commission to participate in the program.

(b) **Active participants**. Subject to the provisions of subsection (c), each local unit employee shall be eligible to participate as an active participant in the local unit plan. Eligibility and participation shall be subject to terms, conditions, limitations, exclusions, and other provisions established by the commission, including the amount and method of payment for employee and employer contributions.

(c) **Waiting periods**.

(1) Each local unit employee whose first day of work for a qualified local unit is on or after the first day on which the employee's qualified local unit participates in the local unit plan shall become eligible for coverage following completion of a 60-day waiting period beginning with the first day of work for the qualified local unit. Each local unit employee shall have 31 days after becoming eligible to elect health insurance coverage.

(2) The waiting period established in paragraph (c)(1) shall not apply if all of the following conditions are met:

(A) The person is returning to work for the qualified local unit, is transferring from another qualified local unit, or is transferring from a position that is eligible for coverage under K.A.R. 108-1-1 or K.A.R. 108-1-3.

(B) Immediately before leaving the prior position, the person was enrolled in the local unit plan, the school district plan under K.A.R. 108-1-3, or the health care benefits program under K.A.R. 108-1-1 or was enrolled in the health care insurance plan provided by the employee's qualified local unit.

(C) The break in service between the prior position and the new position does not exceed the following time periods:

(i) 30 or fewer calendar days; or

(ii) 365 or fewer days, if the person was laid off in accordance with the practices of the prior employer.

(3) The waiting period established in paragraph (c)(1) shall not apply to any person who, on that person’s first day of work for the qualified local unit, is enrolled in the local unit plan, the school district plan under K.A.R. 108-1-3, or the health care benefits plan under K.A.R. 108-1-1 on any of the following bases:

(A) As a direct bill participant;

(B) under the continuation of benefits coverage provided under public law 99-272, as amended; or

(C) as a spouse or dependent of an active participant in any of those plans.

(4) The waiting period established in paragraph (c)(1) may be waived if the chief administrative officer of the qualified local unit, or the chief administrative officer's designee, meets the following requirements:

(A) The chief administrative officer or the chief administrative officer's designee shall provide both of the following certifications to the commission, or its designee, in writing:

(i) A potential new local unit employee is not entitled to continuation of health benefits available from prior insurance coverage.

(ii) The waiting period poses, or will pose, an obstacle to recruitment.

(B) The chief administrative officer or the chief administrative officer's designee shall submit the request for a waiver before the employee's acceptance of the position.

(5) Each local unit employee who is employed by the employee's qualified local unit immediately before the first day on which the employee's qualified local unit participates in the local unit plan shall be subject to transitional provisions established by the commission regarding waiting periods and the date on which the employee becomes eligible to participate in the local unit plan.

(6) The waiting period described in this subsection may be waived by the commission if the commission determines that failure to grant a waiver would create a manifest injustice or undue hardship on the local unit employee.

(d) **Categories of direct bill participants.** Subject to the provisions of subsection (e), the classes of persons eligible to participate as members of the local unit plan on a direct bill basis shall be the following:

(1) Any retired local unit employee who meets one of the following conditions:

(A) The employee is receiving state warrants for retirement benefits under the Kansas public employees retirement system or the Kansas police and firemen’s retirement system.

(B) If the qualified local unit is not a participating employer under either the Kansas public employees retirement system or the Kansas police and firemen’s retirement system, the employee is receiving retirement benefits under the retirement plan provided by the qualified local unit;

(2) any totally disabled former local unit employee who meets one of the following conditions:

(A) The employee is receiving benefits under the Kansas public employees retirement system or the Kansas police and firemen’s retirement system.

(B) If the qualified local unit is not a participating employer under either the Kansas public employees retirement system or the Kansas police and firemen's retirement system, the employee is receiving disability benefits under the retirement or disability plan provided by the qualified local unit;

(3) any surviving spouse or dependent of a qualifying participant in the local unit plan;

(4) any person who is a local unit employee and who is on approved leave without pay in accordance with the practices of the qualified local unit; and

(5) any individual who was covered by the health care plan offered by the qualified local unit on the day immediately before the first day on which the qualified local unit participates in the local unit plan, except that no individual who is an employee of the qualified local unit and who does not meet the definition of local unit employee in subsection (a) shall be qualified as a direct bill participant under this paragraph.

(e) **Conditions for direct bill participants.** Each person who is within a class listed in subsection (d) shall be eligible to participate on a direct bill basis only if the person meets both of the following requirements:

(1) The person was covered by the local unit plan or the health care insurance plan offered by the qualified local unit on one of the following bases:

(A) Immediately before the date the person ceased to be eligible for coverage or, for any person identified in paragraph (d)(5), immediately before the first day on which the qualified local unit participates in the local unit plan, the person either was covered as an active participant under subsection (b) or was covered by the health care insurance plan offered by the employee's qualified local unit.

(B) The person is a surviving spouse or dependent of a person who was enrolled as a plan participant under subsection (b) or (d) at the time the plan participant died, and the person was enrolled in spouse or dependent coverage under subsection (g) at the time the plan participant died.

(C) The person is a surviving spouse or dependent of a person who was enrolled as a plan participant under the health care insurance plan offered by the participant's qualified local unit at the time the participant died, and the person was covered under the same plan at the time the participant died.

(2) The person files a statement of election with the commission's health benefits administrator to continue coverage under the plan. The election to continue coverage shall be submitted on a form prescribed by the commission's health benefits administrator. The form shall be submitted no more than 30 days after the person ceased to be eligible for coverage or, in the case of any individual identified in paragraph (d)(5), no more than 30 days after the first day on which the qualified local unit participates in the local unit plan.

(f) **Continuation of benefits (COBRA) coverage.** Any individual with rights to extend coverage under provisions of public law 99-272, as amended, may participate in the local unit plan, subject to the provisions of that federal law.

(g) **Coverage of spouses and dependents.** Any person who is enrolled in the local unit plan under subsection (b), (d), or (f) as a primary participant may enroll the following dependents, subject to the same conditions and limitations that apply to the primary participant:

(1) The primary participant's lawful wife or husband; and

(2) any of the primary participant's eligible dependent children. An eligible dependent child who is enrolled in the local unit plan by one primary participant shall not be eligible to be enrolled by another primary participant in the local unit plan, the school district plan under K.A.R. 108-1-3, or the health care benefits program under K.A.R. 108-1-1.

(h) **Eligible dependent participants; definitions.** For purposes of subsection (g), "primary participant," "child," and "eligible dependent child" shall be defined as those terms are defined in K.A.R. 108-1-1.

(i) Direct bill participants; continuous coverage provisions.

(1) Except as otherwise provided in this subsection, each direct bill participant enrolled in the local unit plan shall maintain continuous coverage in the program or shall lose eligibility to be in the local unit plan as a direct bill participant under subsection (d).

(2) Any person who discontinues direct bill coverage in the local unit plan and maintains continuous coverage in a medicare risk plan may return to the local unit plan according to the open enrollment procedures.

(j) An individual who is eligible to enroll as an active participant under subsection (b) and whose spouse is eligible for coverage as an active participant under K.A.R. 108-1-1 shall not be eligible for coverage as a dependent under K.A.R. 108-1-1. Any other dependents of the individual and the individual's spouse may be enrolled under the provisions of either K.A.R. 108-1-1 or K.A.R. 108-1-4. (Authorized by K.S.A. 2002 Supp. 75-6501 and K.S.A. 75-6510; implementing K.S.A. 2002 Supp. 75-6501 and K.S.A. 75-6508; effective August 30, 2002; amended March 28, 2003; as amended.